Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Division of Child Care (DCC)
Division of Regulated Child Care (DRCC)

Kentucky Integrated Child Care System (KICCS) Provider Portal Access Agreement

Form and Online Request Instructions

General Procedure

An applicant for a new Provider Portal Account must have a citizen account accessible thru the Kentucky Online Gateway, submit a readable copy of their driver's license or state photo ID, and complete and submit this form to obtain access to KICCS portal online features. This form must be completed in ink or typed, all information must be accurate and complete, and the form must contain the appropriate authorized signature(s) from an owner or authorized agent registered with the Kentucky Secretary of State's Office. When the form is completed, it must be submitted for approval to CHFS.

- **Step 1**: Print this form. One form must be submitted for each user requesting an account and for each license number.

- **Step 2**: Follow the instructions available on the Portal Launch at http://chfs.ky.gov/dcbs/dcc/kiccsportal/ site to create a citizen account or request KICCS portal roles thru the Kentucky Online Gateway. *If you need help completing the online request, contact the KICCS HelpDesk (502) 564-0104, option 6 or toll free at 866-231-0003 Option 6.*

- **Step 3:** Complete ALL applicable fields on this form. Handwritten information must be legible**.** Access will not be granted if the user information is incomplete or illegible when the form is submitted.

- **Step 4:** Please ensure the Administrator Signature line is signed by the owner or registered agent documented with the Kentucky Secretary of State.

- **Step 5:** This completed form, a copy of your driver's license or valid photo ID issued by the state should be submitted electronically at fax number 502-564-3464 or by email to: Portal.Access@ky.gov.

  If you prefer, you may mail these documents to: Division of Child Care, 275 E. Main St, 3C-F, Frankfort, KY 40621, ATTN: CCAP Portal Administrator.

  IMPORTANT: Please enlarge and lighten your driver's license before faxing it to make the image easier to read.

For questions or assistance, please call the help desk at (502) 564-0104, option 6 or toll free at 866-231-0003 Option 6.

Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Division of Child Care (DCC)
Division of Regulated Child Care (DRCC)

Kentucky Integrated Child Care System (KICCS) Provider Portal Account Agreement

SECTION 1: USER INFORMATION

REQUEST DATE: _____ KY DL/PHOTO ID NO. _____

FIRST NAME: _____ M.I. _____ LAST NAME: _____

EMAIL USED ON KOG: _____

PRIMARY PHONE: (___) _____ SECONDARY PHONE: (___) _____

ENTER NAME OF THE HEAD OF ORGANIZATION/OWNER: _____

BUSINESS NAME: _____ FAX NUMBER: _____

CERTIFIED, **L**ICENSED OR **R**EGISTRATION NO. _____
(If you have multiple centers, and need additional space to enter information, attach a separate piece of paper listing information for each. The business name for each C,L,R is required)

BUSINESS MAILING ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____ COUNTY: _____

SECTION 2: KICCS PROVIDER PORTAL ACCOUNT USER AGREEMENT

By accepting this user agreement, I acknowledge that I have been made aware of my responsibilities to protect the confidentiality of the information in the KICCS Provider Portal Account. I am only permitted to use KICCS Provider Portal Account for the purpose of reporting child care activity for payment and/or filing Renewal and Provider Change Request applications online through CHFS in Kentucky. I acknowledge that I have been made aware that misuse of the information may potentially lead to penalties and/or system revocation.

As an authorized user, I agree to the following terms of use:

1. I agree to make only authorized use of any information in the KICCS Provider Portal Account. I agree to not divulge the contents of any record except as permitted by state or federal law.
2. I agree to not share any user name or password information. I acknowledge that I am responsible for any actions taken on the KICCS Provider Portal Account under my login name.
3. I agree not to access the information contained in the KICCS Provider Portal Account other than for authorized business actions.
4. I agree to terminate my access to the KICCS Provider Portal Account when my employment with the reporting entity ends or when my job responsibilities no longer require me to access KICCS Provider Portal Account information.
5. I agree to immediately report any misuse of the KICCS Provider Portal Account or violations of this agreement to the CHFS IT Security Officer.

Any misuse of the KICCS Provider Portal Account or its information may lead to temporary revocation of access privileges, permanent loss of access privileges or penalties under state and/or federal law.

SECTION 3: AUTHORIZATION SIGNATURE FOR ALL ACCOUNT REQUESTORS

I attest to the best of my knowledge that the information provided above is true, accurate, and complete and that I have read and agree to the KICCS Provider Portal Account user agreement terms within this document.

►_____►_____

YOUR SIGNATURE HERE **DATE**

Your Printed Name *(must be legible):* _____

►_____►_____

YOUR ADMINISTRATOR SIGNATURE HERE (IF YOU ARE THE OWNER, HEAD OF ORGANIZATION, OR ADMIN, SIGN HERE AGAIN) **DATE**

Your Administrator Printed Name *(must be legible):* _____

Section 4 is for the Division of Child Care/Division of Regulated Child Care staff only. Do not write below this line.

SECTION 4: AUTHORIZATION SIGNATURE(S) FOR CCAP ADMINISTRATORS ONLY

I certify that the job duties of the User requires access to the program(s) requested and that the access complies with appropriate use as specified in the KICCS Provider Portal Account User Agreement.

CCAP ADMINISTRATOR: _____ **DATE:** _____